Vaccine Administration Record

Information About Person to Receive Vaccine (please print)					
Patient Medicaid Number:			Patient Social Security Number:		
Name: *Last*	*First*	*Middle Initial*	*Birthdate*	*Sex*	*Race*
Address: *Street*	*City*	*County*	*State*	*Zip*	

For Clinic/Office Use Only

Eligibility Status — VFC: ☐ Uninsured ☐ Medicaid ☐ American Indian ☐ Insured *(Insurance does not cover Immunizations)*
Insured: ☐ CHIP ☐ Other *(Insurance covers Immunizations)*
☐ None of the above

Clinic Code: _____ Date Vaccinated & VIS issued: _____/_____/_____

☐ DTaP/Hib ☐ DTaP ☐ DTap/IPV/Hib ☐ DTap/IPV
☐ Td ☐ Tdap ☐ DTap/IPV/HepB
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Arm* ☐ *Left* ☐ *Thigh*
VIS Revision Date _____/_____/_____

IPV
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Arm* ☐ *Left* ☐ *Thigh*
VIS Revision Date _____/_____/_____

MMR
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Arm* ☐ *Left* ☐ *Thigh*
VIS Revision Date _____/_____/_____

☐ Hib (PRP-OMP) ☐ Hib (PRP-T)
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Arm* ☐ *Left* ☐ *Thigh*
VIS Revision Date _____/_____/_____

☐ Hep B ☐ Hep B/Hib
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Arm* ☐ *Left* ☐ *Thigh*
VIS Revision Date _____/_____/_____

Varicella
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Arm* ☐ *Left* ☐ *Thigh*
VIS Revision Date _____/_____/_____

Prevnar (PCV7)
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Arm* ☐ *Left* ☐ *Thigh*
VIS Revision Date _____/_____/_____

Hep A
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Arm* ☐ *Left* ☐ *Thigh*
VIS Revision Date _____/_____/_____

☐ RotaTeq ☐ Rotarix
Manufacturer and Lot Number
Oral
VIS Revision Date _____/_____/_____

HPV
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Arm* ☐ *Left* ☐ *Thigh*
VIS Revision Date _____/_____/_____

☐ Menactra ☐ Menomune
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Arm* ☐ *Left* ☐ *Thigh*
VIS Revision Date _____/_____/_____

Influenza
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Arm* ☐ *Left* ☐ *Thigh*
VIS Revision Date _____/_____/_____

Other
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Arm* ☐ *Left* ☐ *Thigh*
VIS Revision Date _____/_____/_____

Other
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Arm* ☐ *Left* ☐ *Thigh*
VIS Revision Date _____/_____/_____

Other
Manufacturer and Lot Number
Injection Site ☐ *Right* ☐ *Arm* ☐ *Left* ☐ *Thigh*
VIS Revision Date _____/_____/_____

Prior to administration of the vaccine(s) checked above, a copy of the Vaccine Information Statement for each vaccine was provided to the client or representative of the child to whom the vaccine was administered. The client or his/her representative was given the opportunity to ask questions regarding the vaccine.

Prior to administration of the vaccine(s) checked above, a copy of the Vaccine Information Statement for each vaccine was provided to me. I was given the opportunity to ask questions regarding the vaccine(s) and agree to its administration.

_____ *Signature of Vaccine Administrator/Title*

_____ *Signature of Vaccine Recipient or his/her Parent or Representative*